

Tavistock and Portman E-Prints Online

JOURNAL ARTICLE

Original citation: Searle, Liz and Lyon, Louise and Young, Linda and Wiseman, Mel and Foster-Davis, Beverly (2011) [The young people's consultation service: An evaluation of a consultation model of very brief psychotherapy](#). *British Journal of Psychotherapy*, 27 (1). pp. 56-78. ISSN Print ISSN: 0265-9883 Online ISSN: 1752-0118

© 2011 Liz Searle et al.

This version available at: <http://repository.tavistockandportman.ac.uk/>

Available in Tavistock and Portman E-Prints Online: 2011

The Trust has developed the Repository so that users may access the clinical, academic and research work of the Trust.

Copyright © and Moral Rights for the papers on this site are retained by the individual authors and/or other copyright owners. Users may download and/or print one copy of any article(s) in Tavistock and Portman E-Prints Online to facilitate their private study or for non-commercial research. You may not engage in further distribution of the material or use it for any profit-making activities or any commercial gain. You may freely distribute the URL (<http://repository.tavistockandportman.ac.uk/>) of Tavistock and Portman E-Prints Online.

This document is the published version of 'The young people's consultation service'. It is freely available online. You are encouraged to consult the remainder of this publication if you wish to cite from it.

THE YOUNG PEOPLE'S CONSULTATION SERVICE: AN EVALUATION OF A CONSULTATION MODEL OF VERY BRIEF PSYCHOTHERAPY

*Liz Searle, Louise Lyon, Linda Young, Mel Wiseman and
Beverly Foster-Davis*

ABSTRACT The Young People's Consultation Service (YPCS) is a four-session, self-referral, psychodynamically-oriented psychotherapeutic consultation service for young people aged between 16 and 30, at the Tavistock and Portman NHS Foundation Trust in London.

Aim: It was hypothesized that clients would show an improvement on outcome measures at the end of the four sessions. It was also hoped that the data would identify characteristics of the clients who show the most benefit.

Method: A review of the case-notes of all clients attending the service between January 2003 to April 2006 was carried out, and details were entered into a database, including demographic information, presenting issues and attendance. Clients were given the Youth Self-Report form (YSR) (Achenbach, 1991) or the Young Adult Self Report form (YASR) (Achenbach, 1997), according to age, before the start of the intervention and at the end of the four sessions. Outcome data were analysed, comparing pre- and post-treatment scores on the YSR/YASR.

Results: A total of 236 clients attended the service during the study period. Pre- to post-comparison data on the YSR/YASR was available for 24 clients. Of those, YSR/YASR scores reduced significantly on all subscales and severity reduced over time in all cases. In addition, there was a trend towards moving from the clinical to the non-clinical range, reaching statistical significance on the Internalizing and Total subscales. A number of YPCS clients showed both statistically significant and clinical improvement on the Internalizing and Externalizing scales of the YSR/YASR, with a greater number showing improvement on the Internalizing scale.

Conclusions: Improvements were found on all subscales of the YSR/YASR at the end of the four session intervention. A greater number of clients showed improvement on the Internalizing subscale, suggesting that this form of very brief psychotherapy is most effective for clients with emotional problems.

Key words: very brief psychotherapy, consultation, brief psychotherapy, young people, psychotherapy, self-referral, psychodynamic, therapy outcomes, adolescent psychotherapy, transition

LIZ SEARLE is a Specialist Registrar in Child and Adolescent Psychiatry at Great Ormond Street Hospital and has previously worked within the YPCS [liz.searle@nhs.net].

LOUISE LYON is Trust Director and Consultant Clinical Psychologist at the Tavistock and Portman NHS Foundation Trust (TPNHSFT). She was formerly the head of the YPCS and has previously published a paper on the YPCS in the *British Journal of Psychotherapy* [LLyon@tavi-port.nhs.uk].

LINDA YOUNG is a Consultant Clinical Psychologist at the TPNHSFT and is the current head of the YPCS. She organizes seminars, running over one year: 'Working in the Young People's Consultation Service' [lyoung@tavi-port.org].

MEL WISEMAN is a Clinical Psychologist for the Northamptonshire Healthcare NHS Trust: she previously worked as an Assistant Psychologist at the TPNHSFT when she was involved in the analysis of outcome data for the service [melwiseman@nhs.net].

BEVERLY FOSTER-DAVIS is the Brief Consultation Services Co-ordinator with administrative responsibility for the YPCS at the TPNHSFT [BFoster-Davis@tavi-port.nhs.uk].

© The authors

British Journal of Psychotherapy © 2011 BAP and Blackwell Publishing Ltd, 9600

Introduction

The Young People's Consultation Service (YPCS) offers a four session intervention to people aged between 16 and 30 who would like to discuss an emotional or personal issue. The aim is to provide a service that is easy to access and confidential, allowing the client space to think with a professional.

This paper gives an overview of the YPCS, including describing the history of the service, with an outline of the YPCS model and a case vignette to exemplify the therapeutic process. The relevant literature on very brief psychotherapy is explored: although the consultation model of the YPCS is not intended to be psychotherapy as such, this body of work provides the most relevant comparison. The paper then proceeds to report on an analysis of outcome data. It was hypothesized that clients would show improvements on outcome measures after four sessions. The evaluation of outcome will provide information about which clients seem to show the greatest benefit and enable the service and funders to assess its effectiveness.

History of the YPCS

The YPCS was set up in 1961 as a voluntary counselling service for any young person without the need for a formal referral. The original staff were a mixture of psychoanalytically-oriented social workers and psychologists. The aim of the formative service was to offer an intervention for people whose problems were seen as part of the 'normal' maturational process rather than 'pathological'.

The founders' hope was to offer a service that was:

independent of the adolescent's world of authority, to which young people may come and discuss their immediate problems without any need for a deep or permanent relationship being created . . . The adolescents, by discussion with well-trained advisers, can work out their own problems and attain insight into them so that they may return to their milieu and make growth and progress. (Lyon, 2004, p. 30)

The service was set up to be brief, targeting a particular young client group who may be 'cautious and . . . curious, cautious about commitment but curious about themselves' (Dartington, 1995, p. 253).

The age range of 16 to 30 covers the extended transition phase between adolescence to establishing oneself as an adult. This period involves negotiating several milestones, including moving from school to university or the workplace, leaving home to become an independent adult, developing adult sexual relationships, and establishing one's adult identity. The self-referral nature of the service inherently excluded under-16s as it was a legal requirement for parental consent below that age.¹

In the UK, there is an increasing recognition of the importance of providing mental health services that cover this transition from adolescence to adulthood (e.g. Lamb *et al.*, 2008). The adolescent phase does not suddenly end when the young person turns 18 and there is evidence that the brain continues to develop into the early 20s (Dahl, 2004). Thus the YPCS was perhaps ahead

of its time in offering a service that crosses the traditional age boundaries between child and adolescent and adult mental health services.

The problems that clients present with are usually those of everyday life. The aim from the outset was for young people to be seen quickly during a time of crisis or change, to strengthen their own resources and avoid acting out through unconscious impulses. The service thus provides 'an important preventive mental health function' (Dartington, 1995, p. 260).

The informal nature of the service was unique at the time of the service's inception and was maintained when it became part of the NHS in 1967 under the auspices of the Tavistock Clinic in North London, where it remains within the Adolescent Department.

In terms of reviewing outcomes and related services, the literature on very brief psychotherapy provides the most relevant comparison. This body of work is reviewed below as well as pertinent material on psychodynamic counselling. This is followed by detail of the YPCS model and a case vignette to illustrate the intervention.

Very Brief Psychotherapy

The concept of very brief psychodynamic psychotherapy may initially seem paradoxical. However, Freud himself practised psychoanalysis within a shorter time-scale than modern standards: six months was considered long. He experimented with setting a definite ending date from early on in therapy. Similarly, other influential analysts, such as Jung, Klein and Winnicott all saw patients for short periods. Other early analysts, including Ferenczi and Rank, advocated time-limited treatments, focusing on the 'here-and-now'. Although brief psychotherapy was not originally a different entity, it began to develop as such through the work of Malan and Balint in the 1950s. Malan studied waiting lists for psychotherapy and observed that people who had been assessed but not been taken on showed real improvements (Malan *et al.*, 1975). He concluded that the assessment itself had been a significant encounter which helped the client to reframe their difficulties, strengthen their self-understanding and facilitated their seeing a way forward.

In spite of the variety of theoretical models that have evolved from this work, there are some general agreements among brief psychotherapy theorists and clinicians about key elements for success. Firstly, the client should have a high motivation for change. Secondly, there should be a circumscribed problem and a clear focus: this should be promptly formulated by the psychotherapist in order to maximize the use of the limited time. Coren (1996) argues that the central focus must encompass the 'triangle of insight' (Flegenheimer, 1982), that is, linking between the current life circumstances, past history and what happens in the room. Thirdly, the ending is thought about from the start. This is considered to concentrate the minds of both client and therapist, intensifies emotions and allows a working through of former losses. 'Working with the end from the beginning enables core attachment issues to be addressed' (Lee, 2004, p. 5). Facilitating good endings is particularly important when working with young people as this phase of development is characterised by losses in the form of

ending of the childhood relationship with parents, leaving the family home and progression to adult roles in life.

In their seminal paper, Howard *et al.* (1986) challenged the previous notion that it was the quantity of treatment that was associated with therapeutic benefit. Much psychotherapy research focuses on length of therapy as the crucial variable, with many studies showing a positive association between the amount of treatment and outcome. But what is the active ingredient? While this is often taken as length of therapy or number of sessions, Howard compares this to an analogy of weight in different medicines, that is, they are not necessarily equivalent. Howard *et al.* (1986) conducted a meta-analysis on length of psychotherapy and examined whether there is a dose–response relationship:² that is, whether increased amounts of psychotherapy are associated with change. They found that there was an acceleration of improvement early on in therapy: over two thirds of the therapeutic benefit is seen in the first 25 sessions. Many showed improvements even sooner. Between 29–38% of patients studied improved within the first three sessions, regardless of how long therapy was. For those whose treatment lasted 4–7 sessions, 38% improved between sessions 1–3 and 58% improved by sessions 4–7.³ These figures would be considered remarkable for many modern medicines,⁴ i.e. for over half of patients to improve in only 1–2 months. However, it is of note that this meta-analysis includes studies using various models of psychotherapy, mainly interpersonal and psychodynamic,⁵ in a variety of settings, from private practice to university counselling centres; and, importantly, using a range of outcome measures, including both therapist and client self-ratings. This heterogeneity makes comparison between studies complex.

Barkham *et al.* (1999) explored the dose–response effect further with a study of the ‘Two-Plus-One’⁶ psychotherapy model. They argued that Howard’s work was flawed in that it did not examine time-limited psychotherapy: for example, clients may have shown a rapid improvement safe in the knowledge of an agreement for further sessions. Barkham and colleagues found that clients showed a significant improvement at the end of the three-session psychotherapy.

Aveline (2001) reported on a randomized controlled trial (RCT) of a ‘Three-plus-one’ model,⁷ comparing this very brief psychodynamic intervention with their standard four-session assessment for psychotherapy. They found that patients preferred this intervention over the usual assessment and it was associated with significant cost savings. As a result, they have adopted this model as their standard assessment process.

There is a relevant literature on student counselling (e.g. Coren, 1996, 1999). Many such services operate within a psychodynamically-oriented framework similar to the YPCS model described here, typically offering between four to six sessions. Coren (1996) argues that such consultations should not simply be seen as second best to longer-term psychotherapy, and that they can be attractive to young people because of the inherent therapeutic hope and lack of procrastination and pathologizing. Such work with adolescents and young adults has the benefit of allowing the young person to continue with normal

developmental tasks and to get on with the business of life outside the consultation room.

Very brief psychotherapy requires particular skill on the part of the therapist. While the time-limited nature means that time is precious, this should not be a reason to rush. Pacing of the therapy is thus a crucial part of the psychotherapist's role. Excessive use of interpretations may be overwhelming for the client. There is less margin for error or possibility for repair in the case of a misinterpretation. Many would argue that the use of reflections to test out hypotheses, on the other hand, is appropriate: 'To do this well requires knowledge, skill and sensitivity' (Aveline, 2001, p. 373).

Given the limited time, the rapport and trust between therapist and client need to be swiftly established. It may be that the crucial variable in brief psychotherapy is this therapeutic relationship. Holmes (1994) argues that it is quality rather than quantity that is essential for secure attachments and this analogy may be logically extended to psychotherapy. It has been argued that 'positive therapeutic alliance' is a good predictor of positive outcome in therapy (e.g. Orlinsky & Howard, 1986). Other models of psychotherapy, such as cognitive behavioural therapy (CBT), initially ignored this aspect, but have increasingly come to acknowledge the value of the therapeutic relationship.

For the therapist, very brief psychotherapy poses special challenges. While this form of therapy is inherently short, it need not be superficial. Indeed, these very brief encounters can be particularly intense. Endings can be difficult for the therapist and may be experienced as a loss, which can be difficult for those clinicians who specialize in this field (Lee, 2004). This requires careful and skilled supervision. On the other hand, the psychotherapist benefits from the richness of sharing these intense experiences with more clients and there is greater opportunity for 'learning from the patient' (Casement, 1985). The work can be especially satisfying when tangible improvements can be simultaneously witnessed by both client and therapist.

The YPCS Model and Therapeutic Process

The YPCS may best be seen as a *consultation model of very brief psychotherapy*. It offers a *consultation* to the young person rather than psychotherapy as such. Nevertheless, the intention is to offer an intervention that is *therapeutic*. The consultation aims to engage young people by offering an easy to access space to think about their difficulties, through its self-referral and brief nature, with short waiting times. The intervention is referred to as either a 'consultation' or 'psychotherapy' for the purposes of brevity in this paper.

The YPCS is limited to four sessions of 50 minutes each.⁸ This may be the person's first and only experience of a psychological intervention, or it may act as a taster for longer-term therapy. The four-session contract is clearly defined to clients at the outset and this is felt to have a containing function. The four session dates are given at the start of the consultation and reminders are not usually sent in the case of a client missing a session. This is to promote the client taking responsibility for the psychotherapy and to prevent a sense of persecution.

The focus tends to be on the client's current situation, allowing space for self-exploration and promoting growth, without encouraging dependency. The client is able to start to make use of careful interpretations offered by the psychotherapist. Indeed, the brief nature of the service requires special skills on the part of the psychotherapist as it is key to move at the client's pace. The therapist may become aware of emotions that remain subconscious for the client, and it may not be appropriate in this setting to delve further into this: this requires skilled clinical judgement.

At the end of the four sessions, some clients feel they would like to continue with longer-term psychotherapy. While this is something that may be thought about in the final session, it is considered important to see this as a brief therapeutic process in its own right and to encourage the client to make use of this space. Young people may be given information about appropriate services although formal referrals are not routinely made. Some clients progress to be seen for longer-term psychotherapy in the Adolescent or Adult Departments at the Tavistock and Portman NHS Foundation Trust (TPNHSFT). Others may decide they do not want further psychotherapy, while in some cases it may be considered by the therapist that this may not be the right time to go on for longer-term psychotherapy. Indeed, some people may not complete the four sessions for various reasons.

Clients can attend for a second intervention within the YPCS at a later stage should they wish. In fact, four clients in the time period studied had had two separate interventions in the YPCS. Whatever the outcome, it is hoped that the young person has gained something from the consultation that they will take away to assist them to continue on their life's journey.

It is often important to consider what makes a client choose such a time-limited intervention. It may be lack of knowledge of the therapeutic world, shortage of time, a means of 'dipping their toes in the water' of their own psyche or an avoidance of or ambivalence about engaging in deeper therapeutic work. Some may simply not need longer-term therapy, in which case this consultation is a good fit. This question is often held in the psychotherapist's mind and can serve as a tool for understanding the client's position.

The service operates within a psychodynamic framework and the therapists come from a variety of professional backgrounds including psychiatrists, psychologists, psychotherapists and counsellors.⁹ Some are employed by, or in training at, the TPNHSFT, while others may participate in the service on an honorary basis as part of external training or to gain experience. Due to the large number of psychotherapists available, most clients can be offered an appointment within a week or two of their initial contact.

Each psychotherapist is allocated to a weekly supervision group led by an experienced clinician. Transference issues are thought about in supervision, but direct transference interpretations are not usually made in the sessions. Countertransference feelings, on the other hand, are often used indirectly to help identify issues for that client. For example, the psychotherapist may draw on their own experience of their relationship with a client to facilitate that person's awareness of links and patterns in their past and present external relationships.

Referral Procedure

The YPCS is a self-referral only service and young people can refer themselves by telephoning the department directly. When the client makes initial contact, the service administrator carries out an initial screening process as to suitability for the service. This includes taking brief details of the problem the person wants to discuss, as well as information regarding previous therapy, whether the person is taking any medication or is known to other services.

The referral is passed on to the Chair of the service for approval. The majority of cases will be accepted at that stage and passed on to a psychotherapist who has availability. Some cases will be considered unsuitable for this service, for example, if they are too complex or too high risk, and can be referred on to somewhere more appropriate.

Apart from this brief screening process, there is no assessment as such, largely due to the aim of offering a brief and easy to access service. The self-referral nature can be difficult for clinicians used to working in more formal mental health services where professionals may be accustomed to having access to detailed information on clients. This lack of knowledge can create anxiety in the psychotherapist. However, this also allows for a more spontaneous approach during the initial encounter with the client, without one's judgement being clouded by assumptions, and being able to experience freely what it is like to be in the room with that person for the first time. Indeed, this can have a levelling effect between client and psychotherapist as the young person will know nothing about the therapist except their name (Dartington, 1995).

Presenting Problems

Common issues that people disclose at the initial contact are that they are feeling depressed or anxious, have had a bereavement, are having family problems or relationship difficulties or breakdown. Many are experiencing difficulties associated with the transition from adolescence to adulthood, for example, problems in studying, difficulties at work, leaving home and separation issues. For these reasons, although most of the clients are young adults, it has been felt that the service is best placed within the Adolescent Department.

It is commonly found that further issues are unravelled during subsequent sessions with the psychotherapist. It is understandable and appropriate that people do not go into full details of their problem during the initial telephone contact with the administrator. For example, a person who initially reports family problems may subsequently disclose a history of abuse. Should significant risk issues emerge during the consultation, the YPCS team have access to psychiatrists within the department, who can arrange to review the young person. This has rarely been necessary but this availability has a containing function for the therapeutic process (Dartington, 1995).

YPCS Case Vignette

The following vignette describes the consultation with one of the clients who showed improvement from the data during the period under study. It

exemplifies the usual YPCS process and key themes that emerge. Some details have been altered to preserve anonymity.

Josie was a 22 year-old young woman who contacted the YPCS, having read about the service in a leaflet at her GP surgery. In the initial telephone contact she said that she was feeling low in mood: she had been depressed in the past and had been prescribed medication but did not want to take this again. She also mentioned problems in her personal life which she thought started in childhood. She had not previously tried counselling or psychotherapy. She was accepted into the service and a psychotherapist was allocated to her case and she was given four session dates, starting within three weeks of initial contact.

In the first session, Josie described to the psychotherapist how she had started feeling depressed again, similarly to when she was 14. She spoke about how she had been travelling recently with her cousin to South America which she had really enjoyed, but was now back at university where she was studying law. She was finding it hard to concentrate on her studies. She also spoke of her current boyfriend of nearly a year, her ambivalence about this relationship and that she did not think he was 'the one'. She had become involved in a partying lifestyle in which her boyfriend was also involved, but wanted to stop this in order to be able to focus more on her studies and career.

In the second session, she said that she had ended the relationship with her boyfriend the previous weekend. She felt upset and was not sure how she would cope over the next few weeks but thought this was the right decision. She then went on to talk about how she felt close to her father but did not get on well with her mother as she did not feel she understood her. [Was this a reference to whether her female psychotherapist really understood her? Perhaps this reflected concerns about becoming attached.] She then went on to talk about how she gets very 'stressed' when she has a big decision to make. She spoke of how she initially finds it hard to commit to relationships; how it had been so difficult to end the relationship with her boyfriend and she worries about not meeting someone else. [This may have been an expression of how hard it would be to end the relationship with her therapist. She might also have been referring to her decision to try this form of very brief psychotherapy and thoughts on whether she should commit to longer-term therapy. She may have been indicating how difficult it was to move from her childhood relationship with her father to having intimate relationships with men and whether she would find someone with whom she shared the same closeness.]

In session three, she talked about having resumed her relationship with her boyfriend the previous weekend. However, they subsequently broke up again a few days later. She spoke about her maternal grandmother's death when she was 13, just before she had previously become depressed. She also talked about the death of a sister who died as a baby when Josie was 2. She did not really remember this but was aware of the impact it had had on her mother in particular. She became very tearful during this session. [The loss of her grandmother appeared to be a significant trigger for her previous episode of depression. The psychotherapist wondered how the tragic death of her baby sister had impacted on the family, and, in particular, Josie's mother. Did she subsequently become depressed herself? How had this affected Josie as a child and was this continuing to affect the relationship between them her and her mother, and, in addition, Josie's capacity to form intimate relationships?] The link between these former losses

and the ending of her current relationship was put to Josie and she was able to acknowledge how she found ending this relationship difficult as it brought back these painful feelings.

In the fourth and final session, Josie asked how the psychotherapist was. [Was this an indication of her concern about how the therapist would feel after their therapeutic relationship ended?] She went on to talk about missing her ex-boyfriend and her sadness about this. She brought photographs of her family to show, including the baby sister who had died and her grandmother, which was apparently very moving for Josie. At the end of the session, she gave the psychotherapist a thank-you card which she had made herself.

This vignette exemplifies some key themes of the YPCS work. As is often the case, the initial contact gives only a clue as to the nature of the underlying issues, which swiftly emerge during the sessions. The preliminary description of feeling low in mood expands to reveal problems around ending a relationship, with further layers of previous unresolved losses. It is of note that Josie decided to end the relationship with her boyfriend during these sessions. Was this merely a coincidence? Perhaps the consultation provided her with a sufficiently safe place and a sense of grounding that enabled her to make this decision, something she acknowledged finding hard to do.

It may be useful to consider Josie's choice of this form of very brief psychotherapy. The ending is clear from the start and it is noteworthy that losses emerged as such a core theme in this case. Given the very brief nature of the intervention, some of the thoughts and questions in the psychotherapist's mind are not directly shared with the client, but are used to focus on what may be core issues for that person. In the final session, Josie wanted to share her life in a more concrete way by bringing in photographs of people who were important to her, maybe as a way of saying how important the therapist had been in their brief time together. She also demonstrated how she had kept the psychotherapist in mind between sessions through having made a card for her, perhaps wondering if the therapist would continue to keep her in mind, and trying to ensure she did so by leaving her with this parting gift.

The consultation had a similarly powerful effect on the psychotherapist. She felt quickly engaged with Josie and was stirred by the material that emerged. She was particularly moved by the issues about death, with these losses painfully present as they worked together towards the ending.

This scenario typifies themes of transition that are common to the YPCS, largely due to the age group of the clients. Josie was struggling with coming to terms with the ending of her childhood relationships with her parents, developing adult responsibilities through leaving her party lifestyle behind in order to focus on her career, and developing intimate adult relationships.

This case also illustrates the type of emotional problems that clients may present with. The issues are not of the complexity that would meet the criteria for adult mental health services, but the consultation is likely to have served an important function in preventing Josie from deteriorating into the depression that she had experienced in her teenage years.

Evaluation of the YPCS

In addition to case material showing an apparent benefit of the four-session consultation model, this study examined outcome data in order to evaluate whether measurable improvements were seen at the end of the psychotherapy.

Method

This study involved a review by hand of the files of all clients who had attended the service from January 2003 to April 2006 inclusive, to obtain demographic data, sessions attended and presenting issue. These details were cross-referenced with the computer records and the information was entered into a database.

Outcome Measures

In order to assess outcome, clients were given the Youth Self-Report form (YSR)¹⁰ (Achenbach, 1991) or the Young Adult Self Report form (YASR) (Achenbach, 1997)¹¹ to complete prior to attending the consultation and at the end of the four sessions.¹² The young person rates themselves on various aspects of emotional and behavioural functioning. This gives scores on various subscales, including internalizing (Anxious/Depressed, Withdrawn, Somatic Problems) and externalizing (Rule Breaking and Aggressive Behaviour) scales and a total problems score.¹³ The measures also provide an assessment of whether people fall within the clinical range: that is, an indication of whether their difficulties are likely to cause significant impairment of their day-to-day functioning. YSR/YASR scores at the start of psychotherapy are compared to those at the end, both in terms of change in mean scores and whether the person has moved from the clinical to the non-clinical range.¹⁴

Results

During the period from January 2003 to April 2006, a total of 236 clients attended the service.

Demographics:

Age

Figure 1 shows the age distributions of patients attending the YPCS by age at initial referral date. The age distribution shows a similar pattern between males and females, with a peak at ages 22–23 and 28–29. It is of note that these peaks appear to coincide with key stages of transition for young people, for example, as they are leaving university or approaching their next decade of life.

Gender

Figure 2 shows the gender of clients attending the YPCS service during the period under study. 71 of the 236 clients (30.1%) were male while 165 (69.9%) were female.

Attendance

Table 1 shows the number of sessions attended by clients: whether they attended all four sessions offered or less. This was further analysed according to

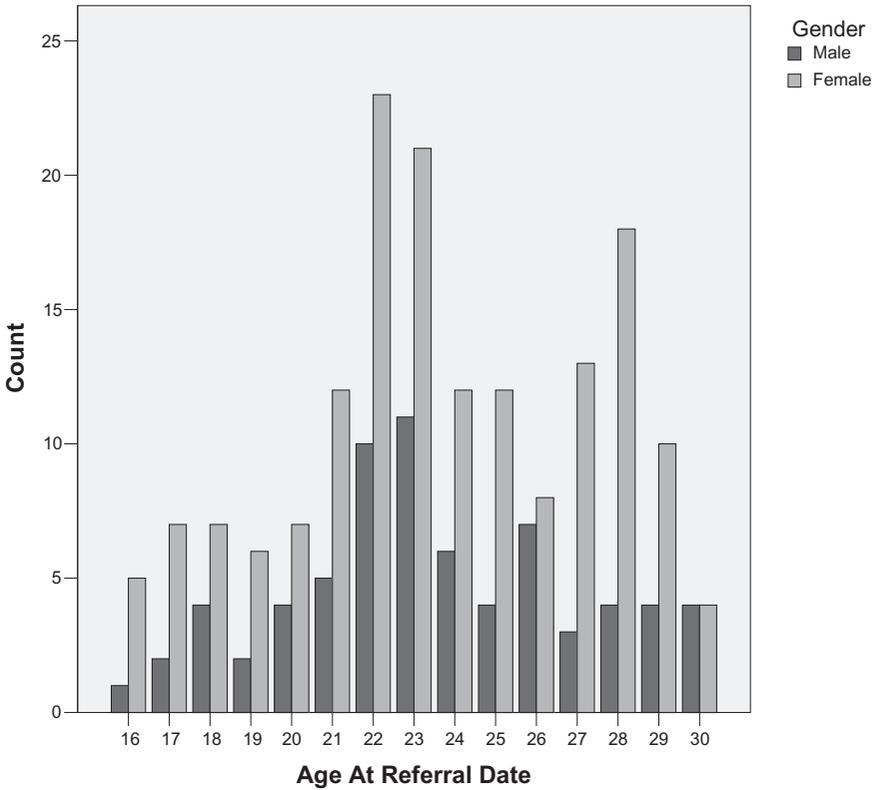


Fig. 1: Age of clients attending YPCS

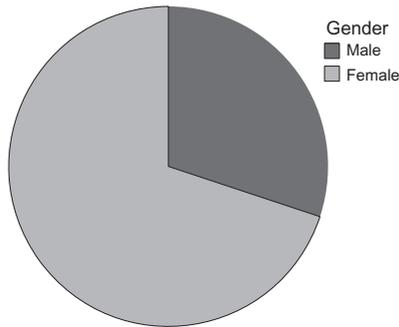


Fig. 2: Gender of clients attending YPCS

gender. 106 people (44.9%) attended all four sessions offered. Males were marginally more likely to attend all four sessions than females, with 34 out of 71 males (47.9%) attending all sessions offered compared to 72 out of 165 females (43.6%).

Table 1. Number of YPCS sessions attended

<i>Sessions attended</i>	<i>Gender</i>		<i>Total (%)</i>
	<i>Male (%)</i>	<i>Female (%)</i>	
Fewer than 4 sessions	37 (52.1)	93 (56.4)	130 (55.1)
All 4 sessions	34 (47.9)	72 (43.6)	106 (44.9)
Total	71	165	236

Attendance and Pre-assessment Scores

The number of sessions attended was compared to YSR/YASR scores before and at the end of the four sessions. This was to test the hypothesis that there may have been some difference between those who attended more sessions compared to those who did not. For example, they may have had more serious problems and were therefore more in need of help. Alternatively, they may have had less severe problems and been less chaotic.

It was found that those who attended all four sessions had significantly lower externalization scores on the YSR/YASR at the start of the psychotherapy (see Table 2), i.e. indicating fewer behavioural problems. The other pre- and post-scores did not show statistically significant differences.

Outcome

Out of 236 clients, 128 completed the YSR/YASR forms at the beginning of psychotherapy and 41 at the end. Of these, 24 clients completed both the pre- and post-therapy forms. Thus pre- and post-psychotherapy comparison could be carried out with 24 cases.

Table 3 shows the mean scores on the YSR/YASR at the start of psychotherapy and at the end of therapy, as well the statistical significance of any change. Of the 24 YPCS service users for whom pre- and post-data was available, scores reduced significantly on all subscales between pre- and post-psychotherapy.

Table 4 shows the percentage of service users that scored within the clinical range on the subscales at each time point. Proportionately more clients were found to fall in the clinical range on the Internalizing scale at the start of the consultation. Further analysis of the subscales revealed that, at the start of the four sessions, 75% of YPCS clients had at least one clinical score and 16% scored at clinical levels on all three scales at assessment.

A significant proportion of clients moved from the clinical to the non-clinical range in the Internalizing ($z = -2.598$, $p = 0.009$) and Total ($z = -2.126$, $p = 0.033$) subscales. On the Externalizing subscale, there was a trend towards moving into the non-clinical range over time, but this did not reach statistical significance.

Reliable and Clinically Significant Change

Consideration of reliable and clinically significant change should provide a more accurate picture of the effectiveness of this consultation. The concept of

Table 2. Comparison of YSR/YASR scores between clients attending four and clients attending fewer than four YPCS sessions

	YSR/YASR subscale	No. of sessions attended	N (%)	Mean	SD	95% confidence interval for mean
Pre-psychotherapy	Internalizing	<4	53 (48)	63.28	10.8	60.3–66.3
	Externalizing	4	57 (52)	63.89	11.0	61.0–66.8
	Total problem score	<4	53 (48)	55.55	10.6	52.6–58.5
Post-psychotherapy	Internalizing	4	57 (52)	51.49	9.7	48.9–54.1
	Externalizing	<4	53 (48)	60.83	10.8	57.9–63.8
	Total problem score	4	57 (52)	59.60	10.0	57.0–62.3
Pre-psychotherapy	Internalizing	<4	10 (33)	59.20	8.8	52.9–65.5
	Externalizing	4	20 (67)	63.50	10.0	58.8–68.2
	Total problem score	<4	10 (33)	55.20	9.5	48.4–62.0
Post-psychotherapy	Internalizing	4	20 (67)	50.80	12.2	45.1–56.5
	Externalizing	<4	10 (33)	59.00	9.4	52.3–65.7
	Total problem score	4	20 (67)	57.45	11.6	52.0–62.9

Table 3. YSR/YASR mean T score and statistical significance of change by sub-scale

	YSR/YASR subscales			N
	Internalizing (SD)	Externalizing (SD)	Total problems score (SD)	
Pre-psychotherapy	63.9 (10.94)	53.9 (10.8)	60.5 (10.36)	128
Post-psychotherapy	61.8 (9.51)	51.84 (11.44)	57.7 (10.6)	41
Pre-post comparison	t(23) = 2.11, P = 0.046*	t(23) = 2.67, p = 0.014*	t(23) = 2.67, p = 0.014*	24

* Statistically significant change.

Table 4. Clinical severity of YSR & YASR T-scores in the YPCS at pre- and post-intervention

		YSR/YASR scales			n
		Internalizing	Externalizing	Total problems	
Pre-psychotherapy	Non-clinical	31%	67%	40%	128
	Borderline	17%	15%	16%	
	Clinical	52%	18%	44%	
End of psychotherapy	Non-clinical	42%	71%	52%	31
	Borderline	16%	10%	10%	
	Clinical	42%	19%	39%	

reliable and clinically significant improvement (RCSI) was described and developed by Jacobson and colleagues (e.g. Jacobson *et al.*, 1984) and has been used to examine change in psychotherapy outcome research. Reliable improvement refers to a difference in scores between pre- and post-psychotherapy that is beyond the natural variance of the YSR or YASR (outside the broken lines in Figures 3, 4 and 5): that is, an improvement that is beyond what might be expected by chance alone.¹⁵ Clinically significant improvement refers to moving from the clinical to non-clinical range of scores. Each YPCS case for which pre-post comparison data was available is represented by a single circle on Figures 3, 4 and 5. Clinical and reliable change is represented by the points outside the broken lines and above or below the solid cut-off lines in the diagrams.¹⁶

Figure 3 shows the distribution of clinical and reliable change in the Total Subscale of the YSR/YASR of the 24 complete sets of data. No clients' scores showed deterioration on this scale.

Further evaluation of the Internalizing and Externalizing scales reveals more detail about the change in scores over time. Examination of Figure 4 shows that a greater number of young people's scores showed improvement on the Internalizing scale. Of the YPCS clients for whom pre-post comparison data was

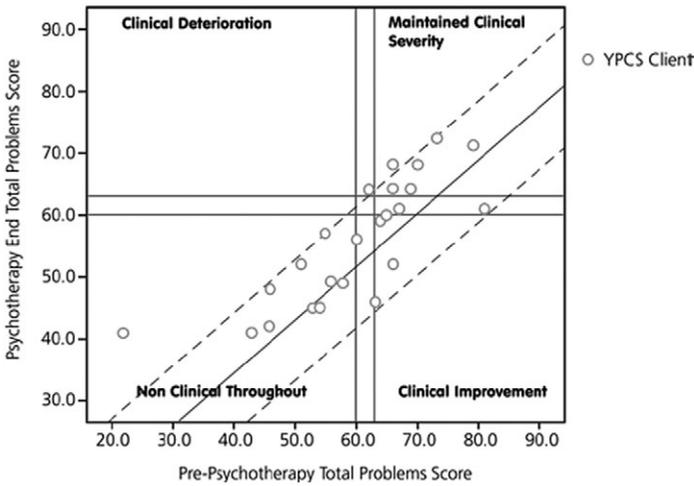


Fig. 3: Reliable and clinically significant change in the YSR and YASR Total Problems Subscale

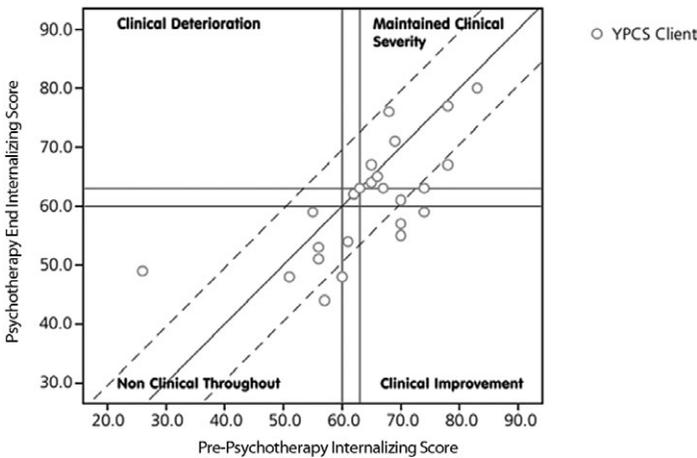


Fig. 4: Reliable and clinically significant change in the YSR and YASR Internalizing Scale

available, 7 (29.2%) showed reliable improvement, 3 (12.5%) of whom showed both clinical and reliable improvement on the Internalizing scale. None showed deterioration.

Figure 5 demonstrates the reliable and clinical change on the Externalizing scale of the YSR and YASR. At the end of the consultation, 4 (16.7%) of the YPCS group showed reliable improvement, 1 (4.2%) of whom showed both reliable and clinical improvement on the Externalizing scale.

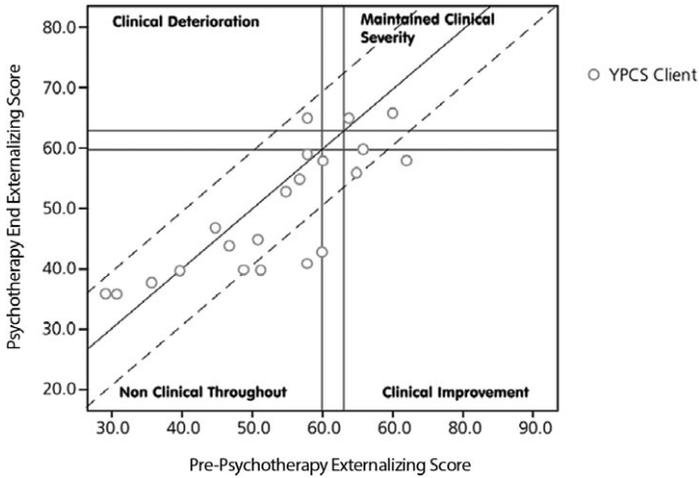


Fig. 5: Reliable and clinically significant change in the YSR/YASR in the YSR and YASR Externalizing Scale

Thus Figures 3, 4, and 5 show that a number of YPCS clients showed both reliable and clinical improvement on the Internalizing and Externalizing scales of the YSR/YASR. The number showing improvement was greater on the Internalizing scale which suggests that the consultation is more effective for symptoms of anxiety and depression.

Discussion

This paper has provided a review of the YPCS, including its history, a description of the model, an overview of the relevant literature and an analysis of outcome.

Outcomes

YPCS service users' scores for whom pre- and post-data were available reduced significantly on all subscales of the YSR/YASR between the start and end of the consultation. Similarly, clinical severity significantly reduced in all cases and on all subscales. There was a trend towards moving from the clinical to the non-clinical range, reaching statistical significance in the Internalizing and Total subscales. Further analysis of the subscales of the YSR/YASR data revealed that a number of YPCS clients showed both reliable and clinical improvement on the Internalizing and Externalizing scales of the YSR/YASR. The number showing improvement was greater on the Internalizing scale which suggests that the brief intervention is more effective at treating emotional problems as opposed to behavioural problems.

Of note, Howard *et al.* (1986) similarly found that those with depressive disorders began responding at the lowest 'doses' of psychotherapy. Likewise, Holmes (1994), following a review of outcome literature in this field, found that people with depression responded well to brief dynamic psychotherapy.

In a study of psychotherapy with young people at another local service, the Brandon Centre, Baruch and Fearon (2002) found markedly lower rates of reliable improvement for externalizing problems and, indeed, found that nearly 12% showed a deterioration. Thus it may be that this type of service is better suited to those with fewer externalizing problems and may be more usefully targeted at young people with more internalizing problems, such as symptoms of anxiety or low mood.

This raises the question of which aspects of the psychotherapy may be less helpful to clients with externalizing problems. Baruch and Fearon (2002) found that a supportive approach, compared with an interpretative approach, was associated with a six-fold increase in the odds of reliable improvement in behaviour problems. Thus it may be that a psychodynamic approach is less beneficial to this group. Other studies have found that more intensive interventions are better for young people with externalizing problems (e.g. Fonagy & Target 1994, 1996; Target & Fonagy 1994). This poses ethical issues about how such a service could be targeted towards those clients who are most likely to experience the most benefit. However, this is inherently difficult within the aims of offering an easy-to-access self-referral intervention.¹⁷

Of note, none of the YPCS clients for whom data were available showed deterioration, including those with higher externalizing scores. Patients build up psychic defences that may serve a useful function. There could be a risk of these being unravelled in very brief psychotherapy without sufficient time to heal. However, if this were the case, it might be expected for people to be worse at the end of four sessions, which was not found here. This provides reassuring information about the safety of this model, although it is acknowledged that the numbers in this sample are relatively small to draw firm conclusions.

Number of Sessions Attended and YSR/YASR Scores

Analysis of the number of sessions attended showed that those who attended all four sessions, compared to those who did not, had significantly lower externalization scores on the YSR/YASR at pre-assessment (see Table 2). This indicates that those with fewer externalizing problems (e.g. rule-breaking and aggressive behaviour) may be more likely to engage in this form of very brief psychotherapy.

Although the number for whom outcome data is available in this study is relatively small, Baruch *et al.* (1998), in their research of psychotherapy at the Brandon Centre, showed similar findings with respect to the type of presenting problems. They found that young people who did not complete the YSR/YASR questionnaire at 1-year follow-up had attended fewer sessions, had higher externalizing scores at presentation and fulfilled the criteria for a diagnosis of conduct disorder.

Thus, as well as apparently showing less benefit, young people with higher externalizing problems seem to be less likely to engage. It may be that this self-referral model of very brief psychotherapy, which requires a client to be reasonably proactive, may not be suited to clients with more behavioural

problems, who may have more chaotic lifestyles. On the other hand, young people with more externalizing difficulties are likely to have greater social problems and, it could be argued, greater need, and more efforts may be required to help these young people to engage in psychotherapy.

Limitations

A major limitation of this study is the relatively low rate of return of the YSR/YASR forms. This makes it difficult to draw wide conclusions about the effectiveness of the consultation. For example, it could be argued that there was something different about those clients who completed the forms, such as that they had less severe problems or that they were unusual in showing improvement. However, the fact that it has been shown to be of clinical benefit to some young people is of value in itself.

This relatively low response rate is not unique to the YPCS as this is an issue generally affecting the use of postal questionnaire methods. The YPCS made attempts to improve the rate of return in October 2005, by changing from posting the end of treatment questionnaire to handing the form to the client in the fourth session. In 2008, 100% of pre-consultation forms were returned and 57% of post-consultation forms were returned. This should improve the reliability and validity of future analyses.

While the YSR/YASR data has shown a benefit of the consultation for some clients at the end of the psychotherapy, the longer-term benefits are not known. It would be of interest to follow-up YPCS clients for a longer period, for example, six months or a year, to be able to assess whether any of the initial benefits have been sustained. However, this is likely to be difficult to achieve in practice. Given that the return rates immediately at the end of the consultation are relatively low, it would be hard to achieve a sufficient rate of returns at a later time to be of statistical or clinical significance. The population of interest are inherently a relatively transient group whom it would be difficult and costly to follow up for longer periods of time. Indeed, the self-referral nature of the service militates against long-term follow-up.

With respect to research methods, the gold standard would be to carry out a randomized-controlled trial (RCT), e.g. comparing this consultation to a control group or to other forms of psychotherapy. This would provide more information about whether it is this intervention that has actually made the difference, e.g. would people have improved anyway over time without the intervention? However, there are intrinsic difficulties with applying RCTs to psychotherapy, e.g. due to the use of non-trained therapists for the control group (Milton *et al.*, 2000). Richardson and Hobson (2000) argue that it is a narrow and oversimplified view to claim that RCTs provide the only real evidence for psychotherapy. Indeed, as improvements were seen after only four weeks in this study, there is support for the idea that the intervention itself has helped, as it would be unlikely for clients to move from the clinical to the non-clinical range in such a short time. Similarly, the fact that other research into psychotherapy in a similar locality has comparable findings supports the validity of this data. Howard *et al.* (1986) argued that most controlled studies have shown psychotherapy to be

more beneficial than spontaneous recovery alone. In addition, there are ethical issues in randomizing young people with known emotional or behavioural difficulties to a no-treatment control group (Kennedy, 2004).

Another limitation is the use of self-reports as the measure of outcome. This is a potential source of responder bias: for example, the client could answer the questionnaire in a way that would please their therapist or attempt to portray themselves in a more favourable light than is true, thus skewing the results. Evidence shows that self-report data are reliable for measuring internalizing problems, but less accurate at assessing externalizing problems (e.g. Baruch *et al.*, 1999). There is a general consensus that reports from significant others tend to provide more accurate information regarding outcome. However, given that the YPCS offers a confidential service to young people aged 16 and over, it would not be appropriate to use an outcome measure relying on collateral information.

Benefit of Very Brief Psychotherapy

Overall, this study demonstrates some benefit of this consultation model of very brief psychotherapy: for people to move from within a clinical range to borderline or non-clinical in only four sessions shows a value of the service.

There is a widely held premise amongst modern psychoanalytic psychotherapists that 'longer is better'. While the small numbers for whom data is available in this evaluation do not refute this idea, it can be concluded that, for some people at least, a benefit is seen with this intervention. This supports Howard *et al.*'s (1986) findings that a significant proportion of patients show the most improvement in the first few sessions of psychotherapy. This paper does not advocate that very brief psychotherapy or a fixed number of sessions should be imposed for all clients – simply that it is a valid option. Similarly, this paper is not arguing that many people do not benefit from long-term psychotherapy, only that some seem to benefit from very brief psychotherapy. In reality, there are likely to be large individual differences in how quickly different people respond to therapy, as found by Barkham *et al.* (2006) in their exploration of the 'Good Enough Level' of psychotherapy.

Baruch and Fearon (2002) found that their clients showed the greatest rate of improvement in the first three months of psychotherapy, which challenged their previous assumption that longer-term psychotherapy would be associated with greater clinical benefits. Indeed, as a result, they have revised their service to also include briefer interventions with shorter waiting times, similar to the YPCS model.

There has been a strong impetus towards the use of other modalities of brief therapy within recent years, notably cognitive-behavioural therapy (CBT). While such approaches are undoubtedly of help to some people, this approach does not suit everyone. Indeed, a RCT by Leff *et al.* (2000) compared cognitive therapy with couple therapy and anti-depressant treatment but found such a high drop-out rate amongst the cognitive therapy group early on in the study that they soon abandoned this arm of the trial. Many clients may not want to do the 'homework' required. In addition, cognitive

methods require the client to be able to access thoughts and feelings at a conscious level. Very brief psychodynamic approaches offer alternative methods for those wanting to explore their psyche in a time-limited fashion.

These results should be of interest to those who are responsible for funding psychotherapy services, as shorter therapy is inherently cheaper. Information about which types of problems show the most clinical improvement will help both funders (e.g. NHS commissioners) and the YPCS to target resources most effectively. Internationally, psychotherapy services are under financial pressure. Under these circumstances, there is a tendency to target resources at those with more severe mental health problems, such as psychotic disorders, with a relative neglect of those with depressive, anxiety or other emotional problems. A significant proportion of clients in this study fell within the clinical range, indicating that the service is not just reaching the 'worried well'. Very brief psychotherapy services, such as the YPCS, are likely to fulfil an important preventative mental health role, which would save money in the longer term.

Conclusion

This paper provides an overview of the Young People's Consultation Service and an evaluation of its effectiveness. The case vignette typifies the work done within the service as well as exemplifying the type of case that was found to show a better outcome. Some limitations of this study have been discussed. As response rates for the outcome measures have improved, it would be helpful to re-evaluate subsequent data in order to assess whether these findings are consistent with a larger sample. This would enable the service to ensure that it is targeted at those who show the most benefit. However, the fact that both clinical and statistical benefit has been demonstrated for at least some young people in only four sessions is of importance. In addition, this consultation model of very brief psychotherapy has a significant value in being of a self-referral nature and having short waiting times, thus being able to respond to clients' needs. The service will continue to develop to meet the requirements of both young people and an evolving health service.

Notes

1. The Fraser Guidelines have subsequently changed this requirement for parental consent for under-16s, provided an adolescent is deemed competent.
2. 'Dose-response' or dose-effect' relationship describes the change in effect caused by differing levels of exposure to an event (usually a drug). This is often used to describe response to a medicine but provides a useful analogy for psychotherapy, e.g. with a 'dose' being the equivalent of a 'session' of psychotherapy.
3. It should be noted that subsequent studies have tended to show a slower response, e.g. about 50% showing improvement at between 13-18 sessions, e.g. Hansen *et al.*, 2002
4. Perhaps with the exception of medication such as antibiotics which have a more rapid mode of action. Few psychotropic drugs would have such efficacy.
5. None were primarily behavioural in orientation.

6. The 'two-plus-one' model involves two sessions one week apart, followed by a third session three months later.
7. This 'three-plus-one' model involves three weekly sessions with a follow-up session three months later.
8. The sessions are usually held on a weekly basis.
9. For the purposes of consistency and brevity in this paper, the therapeutic staff are referred to throughout as 'psychotherapists' although it is acknowledged that they do not all have specific psychotherapy training.
10. The Youth Self Report Form (YSR) (Achenbach, 1991) is used for 11–18 year-olds.
11. The Young Adult Self Report Form (YASR) (Achenbach, 1997) is used for clients over 18.
12. Until October 2005, the YSR/YASR form was posted to the client at the end of treatment. In order to increase returns, this was changed to the form being handed to the client by the psychotherapist in the final session.
13. The Total Problems score is an average of the Internalizing scales and Externalizing scales, with additional scales for Thought Problems, Attention Problems, and Social Problems.
14. Moving from the clinical to the non-clinical range would indicate that the person has changed from a position where their symptoms were having a significant impact on their everyday functioning to a situation where they were less affected. *T* scale scores are used to allow valid comparisons between client groups and individual change over time.
15. For example, this could occur by chance due to unreliability of a measure used.
16. A score between 60 and 63 is borderline clinical (this borderline indicated by the solid lines on Figures 3, 4 and 5), whereas scores over 63 are within the clinical range. Thus, movement from below this cut-off to above 63 would indicate a clinically significant deterioration. Similarly, movement from above to below would indicate clinically significant improvement.
17. Indeed, within the YPCS, the YSR and YASR are not completed until the client arrives for the first session. Thus, the extent to which their problems may be internalizing or externalizing would not be fully known until they are already accepted into the service.

References

- Achenbach, T.M. (1991) *Manual for the Youth Self-Report and 1991 Profile*. Burlington, VT: University of Vermont Department of Psychiatry.
- Achenbach, T.M. (1997) *Manual for the Young Adult Self-Report and Young Adult Behaviour Checklist*. Burlington, VT: University of Vermont Department of Psychiatry.
- Aveline, M. (2001) Very brief dynamic psychotherapy. *Advances in Psychiatric Treatment* 7: 373–80.
- Barkham, M. *et al.* (1999) Psychotherapy in two-plus-one sessions: Outcomes of a randomized controlled trial of cognitive-behavioural and psychodynamic-interpersonal therapy for subsyndromal depression. *Journal of Consulting and Clinical Psychology* 67(2): 201–11.
- Barkham, M. *et al.* (2006) Dose-effect relations and responsive regulation of treatment duration: The good enough level. *Journal of Consulting and Clinical Psychology* 74(1): 160–7.
- Baruch, G. & Fearon, P. (2002) The evaluation of mental health outcome at a community-based psychodynamic psychotherapy service for young people: A 12-month follow-up based on self-report data. *Psychology and Psychotherapy* 75(3): 261–78.

- Baruch, G., Fearon, P. & Gerber, A. (1998) Evaluating the outcome of a community-based psychoanalytic psychotherapy service for young people: One-year repeated follow-up. In: Davenhill, R. and Patrick, M. (eds), *Rethinking Clinical Audit: The Case of Psychotherapy Services in the NHS*, pp. 157–82. London: Routledge.
- Baruch, G., Fearon, P. & Gerber, A. (1999) Emotional and behavioural problems in adolescents/young adults receiving treatment at a community-based psychotherapy centre for young people: A preliminary study of the correspondence among adolescents. *British Journal of Medical Psychology* 72(2): 251–65.
- Casement, P. (1985). *On Learning from the Patient*. London: Tavistock/Routledge.
- Coren, A. (1996). Brief therapy – base metal or pure gold? *Psychodynamic Practice* 2(1): 22–38.
- Coren, A. (1999) Brief psychodynamic counselling in educational settings. In: Lees, J. and Vaspe, A. (eds), *Clinical Counselling in Further and Higher Education*, pp. 58–74. London: Routledge.
- Dahl, R.E. (2004) Adolescent brain development: A period of vulnerabilities and opportunities. *Annals of the New York Academy of Sciences* 1021: 1–22.
- Dartington, A. (1995) Very brief psychodynamic counselling with young people. *Psychodynamic Counselling* 1(2): 253–61.
- Flegenhimer, W.V. (1982) *Techniques of Brief Psychotherapy*. New York, NY: Aronson.
- Fonagy, P. & Target, M. (1994) The efficacy of psychoanalysis for children with disruptive disorders. *Journal of the American Academy of Child and Adolescent Psychiatry* 33: 45–55.
- Fonagy, P. & Target, M. (1996) Predictors of outcome in child psychoanalysis: A retrospective study of 793 cases at the Anna Freud Centre. *Journal of the American Psychoanalytic Association* 44: 27–73.
- Hansen, N.B., Lambert, M.J. & Forman, E.M. (2002) The psychotherapy dose–response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice* 9: 329–43.
- Holmes, J. (1994) Brief dynamic psychotherapy. *Advances in Psychiatric Treatment* 1: 9–25.
- Howard, K.I., Kopta, S.M., Krause, M.S. & Orlinsky, D.E. (1986) The dose–effect relationship in psychotherapy. *American Psychologist* 41(2): 159–64.
- Jacobson, N.S., Follette, W.C. & Revenstorf, D. (1984) Psychotherapy outcome research: Methods for reporting variability and evaluating clinical significance. *Behavior Therapy* 15(4): 336–52.
- Kennedy, E. (2004) *Child and Adolescent Psychotherapy: A Systematic Review of Psychoanalytic Approaches*. London: North Central London Strategic Health Authority.
- Lamb, C., Hall, D., Kelvin, R. & Van Beinum, M. (2008) Working at the CAMHS/Adult Interface: Good practice guidance for the provision of psychiatric services to adolescents/young adults. A joint paper from the Interfaculty working group of the Child and Adolescent Faculty and the General and Community Faculty of the Royal College of Psychiatrists.
- Lee, J. (2004) On brief psychotherapy. *British Journal of Psychotherapy* 21(1): 5–7.
- Leff, J., Vearnals, S., Brewin, C., Wolff, G., Alexander, B., Asen, E., Dayson, D., Jones, E., Chisholm, D. & Everitt, B. (2000) The London Depression Intervention Trial. *British Journal of Psychiatry* 177: 95–100.
- Lyon, L. (2004) Very brief psychoanalytically-based consultation work with young people. *British Journal of Psychotherapy* 21(1): 30–5.
- Malan, D.H., Heath, E.S., Bacal, H.A. & Balfour, F. (1975) Psychodynamic changes in untreated neurotic patients. II. Apparently genuine improvements. *Archives of General Psychiatry* 32(1): 110–26.
- Milton, J., Richardson, P. & Hale, R. (2000) Scarcity of evidence is not necessarily evidence against long-term psychodynamic psychotherapy. *British Medical Journal* 320: 186.

- Orlinsky, D. & Howard, K. (1986) Process and outcome in psychotherapy. In: Garfield, S. & Bergin, A. (eds), *Handbook of Psychotherapy and Behaviour Change*, pp. 56–102. Chichester: Wiley.
- Richardson, P. & Hobson, P. (2000) In defence of NHS psychotherapy. *Psychoanalytic Psychotherapy* 14(1): 63–74.
- Target, M. & Fonagy, P. (1994) The efficacy of psychoanalysis for children with emotional disorders. *Journal of the American Academy of Child and Adolescent Psychiatry* 33(3): 361–71.